

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/14/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>MORNING VIEW NURSING AND REHABILITATION CEI</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>475 NORTH NILES AVENUE</b> <b>SOUTH BEND, IN 46617</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Compliant IN00162707.</p> <p>Complaint IN00162707 - Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey dates: January 13 &amp; 14, 2015</p> <p>Facility number: 013149 Provider number: 013149 AIM number: N/A</p> <p>Survey team: Diana McDonald, RN-TC Brenda Meredith, RN (1/13/15)</p> <p>Census bed type: Residential: 30 Total: 30</p> <p>Sample: N/A</p> <p>Morning View Nursing and Rehabilitation was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00162707.</p> <p>Quality Review completed on January 21, 2015, by Brenda Meredith, R.N.</p>	R 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE